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AUTHOR Dunlop, Jean D.
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ABSTRACT

This report notes the growing awareness of alcohol problems among the elderly during the past 5 to 10 years, and reviews the final conclusions of the federal demonstration project, Senior Alcohol Services. Five basic concepts are included: (1) there are a growing number of elderly persons with alcohol problems (10-15% of all persons over age 60); (2) alcohol problems underlie and/or exacerbate medical problems in the elderly; (3) the elderly as a group are entirely treatable; (4) some unique characteristics of the elderly must be considered in diagnosis and treatment; and (5) effective treatment modalities differ widely. Some innovative and successful treatment approaches are described, and specific clinical issues of use in working with the elderly patient are discussed. Four appendices are included. Appendix A compares symptoms of alcoholism, aging, and drug side effects, and provides information useful to clinicians in making a differential diagnosis. Physiological reasons that alcohol has a more profound impact as the body ages are reviewed in Appendix B, which describes effects of aging and of alcohol on neurological considerations, sleep, heart and circulation, liver, gastrointestinal tract, kidney, nutrition, and stress response. Appendix C looks at clinical treatment issues, listing characteristics that clinicians must consider in treating elderly clients. Appendix D examines family issues in elderly alcoholism. (Author/NB)

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SENIOR ALCOHOL SERVICES REVISITED:

ELDERLY ALCOHOLISM - CURRENT STATE OF THE ART

JEAN DUNLOP, R.N., M.A., C.A.C.

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NATIONAL NURSES SOCIETY ON ADDICTIONS

ANNUAL EDUCATION CONFERENCE

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ABSTRACT

There has been a growing awareness of alcohol problems among the elderly during the past five to ten years. This presentation is designed as a sequel to a paper presented to this group at the 1980 NCA conference in Seattle, Washington.

This paper will review the final conclusions of the NIAAA-funded demonstration project which was then in existence in Vancouver, Washington, and provide information as to the current state of the art in the Pacific Northwest region.

Knowledge resulting from the work done at Senior Alcohol Services will contribute to the ability of the nurse in any setting to be a more effective clinician in working with an elderly patient at any point on the continuum of alcoholism/addiction.

Basic concepts include: (1) that there are a growing number of elderly persons with alcohol problems, i.e., 10%-15% of all persons over 60; (2) that alcohol problems underlie and/or exacerbate medical problems in the elderly; (3) that the elderly as a group are entirely treatable; (4) that some unique characteristics of the population need to be considered both in diagnosis and in treatment; (5) that effective treatment modalities differ widely. Some innovative and successful treatment approaches will be described, and specific clinical issues of use in working with the elderly patient will be discussed.

SENIOR ALCOHOL SERVICES REVISITED:

ELDERLY ALCOHOLISM - CURRENT STATE OF THE ART

JEAN DUNLOP, R.N., M.A., C.A.C.

It has been 2½ years since the federal demonstration project called Senior Alcohol Services ended. This paper is a revisit to the scene. Were the project findings significant? Were they effective in creating change? What is the present state of the art? Where do we go from here? What are the implications for today's nurse?

Let us pause a moment to determine where each of us is emotionally with the topic at hand. Think for a moment of the initial feeling(s) which come to mind when hearing the word "elderly." Now do the same for the word "alcoholic." Do you have awareness of more negative feelings than positive? If you do, you are like the majority of persons this writer has surveyed during workshops given in the past three years. This attitude, which we have called the Double Negative, is one of the primary reasons the problem has so long remained hidden.

Statistics on elderly alcoholism vary widely. Edith Gomberg in 1980 reported that between 2%-25% of elderly are experiencing problems due to alcohol.[1] In surveys conducted in the Pacific Northwest communities of Spokane, Washington, Seattle, Washington, Vancouver, Washington, and Portland, Oregon, figures ranged from 2%-19%.[2]

In spite of the fact that recent surveys indicate that there is a problem of at least equal size to that found in the general population (10%), relatively few treatment programs report serving clients over 60 in numbers that parallel the present over-60 population percentage of 15%-18%.

There are myths and beliefs which have been found to underlie prevalent double negativism toward elderly alcoholism, and they interfere in the providing of help to those in need. Common among these are the belief that the old cannot change and that even if they could, alcohol is one of their last remaining pleasures.

Many believe that the acute organic brain syndrome seen in some elderly alcoholics is irreversible, which supports their belief that it is "too late," and that intervention is likely so useless that it is not worth risking one's relationship with the older alcoholic friend, relative, or patient. Negative attitudes have also frequently been noted among clinicians in alcohol and drug treatment programs who groan inwardly when faced with an elderly client among their caseload of predominantly younger folks. The inward groan is prompted by some of the characteristics of elderly clients which we will talk about later.

Lastly, let us not leave out the negative attitude of the elderly alcoholic himself/herself. This attitude is partly powerful denial made stronger by the greater stigma toward alcoholism found in the elderly and is enhanced by the hardiness with which most elderly view themselves. As a cohort group, they tend to "be strong" and prefer to take care of problems themselves, thus making it hard to acknowledge a need for help.

Another factor keeping elderly alcoholics from receiving help is the hidden nature of their condition. There are not the coercive forces which operate for younger persons to facilitate earlier identification of the problem. Often families are estranged, there is no employer, and the courts are not involved. People who might be instrumental in intervening all too frequently miss the alcoholism, particularly if it is in early to middle stage. This is unfortunately as much the case with the medical profession as it is in social service professions. Both professions are often in a front-line position to diagnose the condition and intervene to provide help. Tragically, the common result is that alcoholism is so completely masked that it is not recognized at all, or it is seen and thought to be the unfortunate and temporary result of some underlying primary problem. Alcoholism, thus unaddressed, continues to progress and to undermine efforts spent to improve other life problems which result from, rather than cause, the alcoholism in most cases.

Because nurses are frequently in a position to intervene in an especially effective and non-threatening way, it is essential that we all become knowledgeable of the signs and symptoms of alcoholism which are so easily masked as the symptoms of aging or other drug side effects. Indeed, all these processes may be going on, but if the alcoholism is not addressed, the patient's condition will deteriorate more rapidly, and efforts to treat other medical conditions will be of dubious benefit. A differential diagnosis is, thus, imperative. Appendix A can be useful in making this diagnosis.

In using this tool, it is important to be aware that the quantity of alcohol being consumed by an older person may not be excessive in relation to that consumed by younger persons or in the opinion of the person making the assessment. More important are the results of the drinking, both acute and chronic. Alcohol, like other drugs, has a more profound impact as the body ages, and as little as three to four drinks per day may put an older person at risk for problems. Some of the physiological reasons for this are reviewed in Appendix B.

Once the nurse has identified alcohol as a problem for an elderly person, the next step becomes one of intervention. The success of this step will depend primarily on the approach that is used. Experience throughout the Senior Alcohol Services project and since then indicates that the "seductive" approach is most effective. It is, of course, critical that the client be still listening when you have finished talking. This will be more likely to happen if the patient perceives that you are on his/her side, rather than approaching the matter in an openly confrontive style. Though this idea runs counter to a method often used with the young, hard-core addict, it was demonstrated during the Senior Alcohol Services project that the elderly respond best to a gently supportive approach which builds on the individual's strengths and buoys self-esteem. Due to the absence of usual coercive forces mentioned above which may be used as motivation for a reluctant younger client (e.g., angry spouse, disgruntled employer, or legal judge), the elderly must often be enticed into a program where they can learn about alcohol and its toxic effects on the body, the insidious process of addiction, and particularly, the devastating effect on the brain which many elderly hope to keep operating at maximum potential for as long as

possible. They then can make an informed decision about the use or non-use of alcohol.

With many elderly, it is important to avoid the use of terms such as "alcoholic" or "alcoholism" because of the strong stigma associated with the condition and its implications for their own self-regard. Making a point of leaving the ultimate decision as to whether to use alcohol or not in the patient's hands, but simply encouraging the gaining of as much information as possible, seems to be a less threatening way to approach the matter, at the same time building self-esteem through the assumption that the client is capable of making a wise decision. It is then up to the treatment program to provide the critical information in such a way (hopefully supportive as well as seductive) as to make abstinence the logical and rewarding outcome.

The matter of ego-strength is an important consideration throughout the entire continuum of treatment and is related to the many irretrievable losses suffered by most elderly. The implications of the "double negative" condition, elderly alcoholism, make it essential that clinicians be aware of the feelings associated with the loss of such things as youth, career, spouse, financial status, health, and mobility. One more loss, i.e., being labeled "alcoholic," at this point, is not needed. There is time enough later in treatment to learn that alcoholism is not the degrading condition it was once thought to be.

Just as alcoholism exists on a continuum, from early-stage relief drinking to late-stage loss of control with severe medical complications, so does treatment follow a progression. At the beginning, or motivational stage, it is necessary to help the patient see that there is a problem. Intervention is the process employed in this phase. Primary treatment usually follows and may be provided on an outpatient or inpatient basis depending on the client's condition and stage of illness. In either case, it is important that the clinician consider the unique characteristics of the elderly client in order to meet his/her needs in treatment. Appendix C lists some of these characteristics.

One of the most important aspects of this primary phase of treatment is the protection from alcohol which it affords the client. As the brain begins to clear, the client may be able to recognize the problems alcohol had been causing. Through counseling, both group and individual, these problems may be addressed and worked through. Also during primary treatment, if in a residential setting, a nutritious diet is assured and as both physical and emotional health improve, a life free of alcohol begins to have some appeal.

In the experience of Senior Alcohol Services, the last phase of treatment was, perhaps, the most critical in terms of successful recovery.[3] This was an open-ended, continuing care, counselor-led, support group. The group met bi-weekly during the afternoon, and members could attend for as many months as they wished. Group time was divided into three parts.

First was a short didactic presention, often a topic covered in treatment which aging brains, still befuddled by the effects of alcohol, had forgotten or never integrated. Next was group therapy to work through the issues of loss, depression, loneliness, failing health, and other personal problems. Finally, a social time was important with time included for reminiscing. Social skills began returning and depression began lifting as people took part in the group interaction.

There was reassurance in being with others who had shared a common life experience and had common life issues and values. Support for sobriety was the basic goal. The group began an "Over 55" A.A. group which is still very active and is the only remaining vestige of Senior Alcohol Services. Occasional contacts with members indicate that sobriety is still intact for many. A.A. is a highly viable component of treatment and recovery for many elderly, particularly if the elements of profanity and references to illegal drugs are at a minimum. Many older clients are offended by those aspects of present day A.A. meetings, thus pointing to the need for "Over 55" A.A. groups. It was found necessary for staff to facilitate the formation of the A.A. group, but once organized, the group became successfully self-led.

Family services were found to be an extremely important part of treatment for those clients who had family members. Issues we discovered and dealt with in individual family therapy, couples weekly group, and a weekly afternoon family group are described in Appendix D.

In summary, during the course of our project, we discovered that elderly alcohol problems exist in about 15% of the elderly population, that those problems underlie and worsen many medical conditions in the elderly, that the elderly as a group are quite treatable and are as successful in recovery as their younger counterparts, that unique characteristics of the population need to be considered both in diagnosis and in treatment, that effective treatment modalities differ widely, and that currently there are many gaps in services.

Following is a description of some successful treatment methods which have been developed in the Portland-Seattle area since the closing of Senior Alcohol Services.

The V.A. Hospital in Vancouver, Washington, began a counselor-led support group for recovery of older veterans which was originally patterned after the Senior Alcohol Services continuing care group. In the last three years the program has grown and now includes seven such groups, which are called "The Class of '45." The model used has aspects of a social group, combined with non-threatening and supportive group therapy. Members are not required to label themselves alcoholic, but there is an understanding that the common goal of all attendees is complete abstinence from alcohol for whatever reason. Counselors report that the weekly groups are enthusiastically attended by members who come early and stay late. In the past several months, these groups have begun to be used as primary treatment for veterans who are over 55 and who are felt to be good candidates for this daytime outpatient approach. It is too early to have a valid success rate, but staff predictions are optimistic.

In a study completed at the hospital in 1984, it was found that the elderly cohort treatment group had an 81.7% attendance rate at scheduled treatment activities and an average length of stay in treatment of 10 months. This compared with a 58% attendance rate and average length of stay in treatment of 5.8 months for the hospital all-age outpatient treatment program. There are implications for this kind of treatment design in terms of cost effectiveness as well as for likelihood of successful recovery. [4]

At Puget Sound Hospital in Tacoma, Washington, where a large percentage of the treatment center population is over 60, a cohort group for older clients is held seven days per week during the three-week primary treatment stay. Here clients work on life issues common to this age group, e.g., loss of spouse, loss of health and mobility, financial worries, as well as feelings about drinking. Many feel that younger clients would not understand these issues and self-disclosure seems easier in the cohort group.

Following the 21-day primary phase, clients return for a once-a-week senior aftercare group held in the morning. This is an open-ended group (clients may continue as many weeks as they wish) and is followed by an "Over 50" A.A. meeting where there is no smoking and no profanity. Puget Sound Hospital also offers more conjoint sessions to older couples but has found that they don't need other special treatment. The conjoint sessions may address the problem of a drinking spouse, thus becoming interventions, which have been 50%-75% successful.

For persons in late-stage alcoholism suffering from organicity or other serious medical impairments, arrangements have been made with a nearby nursing home to provide care until the patient is ready for self-care and treatment. The hospital also provides an initial two to five day detox period prior to admission to the 21-day treatment program.

The Comprehensive Care Unit at Ballard Hospital in Seattle has a similar support group for older clients. This group is led by a nurse facilitator who has worked out a 12-step plan for aging. This idea is combined with the 12 A.A. steps and called The Golden Steps. Any person over 60 may attend this support group, which is conducted weekly on an open-end basis during, as well as following, primary treatment.[5]

A long-term residential program for late-stage alcoholics with debilitating medical problems has been operating in a small community near Portland, Oregon. This program is housed in a convalescent center which provides group and one-to-one counseling to late-stage alcoholics.

The 12 A.A. steps are used in the group sessions and 4th step work is incorporated into the reminiscing being done. Because of the mental impairments of many members, no reading or writing is done in this group. Eighty percent of the members are psychiatrically impaired. Patients may live here for up to one year or longer with the goal being eventual independent living free of alcohol. A low-key treatment approach is used, A.A. meetings are held in the center, and patients are slowly helped to experience the physical and mental benefits of sober living. The average stay has been six to nine months for those able to return to their homes.

In the western Washington town of Aberdeen, a halfway house provides adjustable periods of residency with older clients being helped to gain more comfort and success in sobriety before returning to full independent living. Persons may enter this house for a stay prior to entering treatment as well.

The above-described services for elderly alcoholics have all been started since the Senior Alcohol Services project ended. They are a good beginning, but much remains to be done. Gaps in services are many. There is need for more

awareness on the part of all to recognize alcoholism in older persons. There is need for skilled and sensitive interventionist service to motivate seniors to treatment. There need to be varieties of programs to provide treatment appropriate to the stage of the disease.

Such innovative approaches as the outpatient groups at the Vancouver V.A. being used for primary treatment for early to middle-stage clients, residential free-standing programs for those not physically debilitated but needing the protection from alcohol not found at home, hospital-based residential programs for those needing medical treatment as well, and more long-term, low-key approaches for the late-stage, mentally impaired person would address these various stages. Additionally, there is need for halfway houses to provide an alcohol-free shelter where older persons can build up physical health and mental acuity prior to entering primary treatment. There is the same need for many following primary treatment where older bodies and minds, which take longer to heal, can continue mending in a supportive environment. Serious financial barriers stand in the way of the availability of such services. Medicare covers only that treatment which is provided in a hospital or convalescent care center. Free-standing residential facilities and halfway houses are beyond the means of many elderly people, yet would be much more cost-effective if they could be availed.

Another identified gap is the lack of alcoholism treatment staff trained to work effectively with elderly clients. As well, there need to be programs within existing treatment facilities to address the needs of older clients. These gaps could be closed with relative ease by the provision of staff training and in-house program development. First must come the awareness, which this paper is about. As I write, a coalition of concerned staff from aging, as well as drug and alcohol services in a three-county area near Portland, are meeting to survey the needs of elderly alcoholics and to develop strategies to meet them. Among priorities may be education for prevention. Progress is underway. There is a long way to go.

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Appendix A

THE MASKS ALCOHOLISM CAN WEAR

Differential Diagnosis

ALCOHOLISM	AGING	ADVERSE DRUG REACTIONS
confusion	confusion	confusion
clouding of sensorium	clouding of sensorium	clouding of sensorium
disorientation	disorientation	disorientation
recent memory loss	recent memory loss	recent memory loss
slowed thought process	slowed thought process	slowed thought process
muscle incoordination	muscle incoordination	muscle incoordination
tremors	tremors	tremors
inflamation of joints	inflamation of joints	
gastritis	gastritis	gastritis
hypertension	hypertension	hypertension
depression	depression	depression
congestive heart disease	congestive heart disease	
heart arrythmias	heart arrythmias	heart arrythmias
anorexia	anorexia	anorexia
altered response to stress *exhausted sympathetic nervous system response)	altered response to stress	altered response to stress
	less ability to adjust to stress (measured by urine levels of ACTH and adrenalin)	less ability to adjust to stress (measured by urine levels of ACTH and adrenalin)
malnutrition	malnutrition	
excessive excretion of magnesium & potassium		excessive excretion of magnesium & potassium
edema		edema

Signs and Symptoms of Alcohol Problems May be Masked as Aging, Depression or Drug Side Effects

Medical and/or Physical Disturbances

- Odor of alcohol on breath, on person, and throughout room.
- Alcoholic facies - vascular engorgement, bulbous nose, spider-angioma, orbital edema (usually seen in the late-stage alcoholic).
- Sallow skin.
- Yellow or bloodshot eyes.
- Increased incidence of infection.
- Abnormal bleeding.
- Edema (water retention of hands, ankles, and feet).
- Gastric disturbances (frequent heartburn and indigestion, ulcers, pancreatitis, diarrhea, etc.).
- Overweight and underweight syndrome.
- Cigaretee or other burns on hands, chest or clothing, furniture or carpet.
- Bruises - especially furniture height and back of hands.

Behavior Signs

- Excessive smoking.
- Changes in sleep patterns, especially insomnia.
- Little or no appetite.
- Nesting - a favorite chair with a close table to hold ashtray, drinks, etc., where one can sit and drink, usually facing the T.V.
- Reports of excessive drinking by family and/or others.
- History of alcohol-related arrests.

Behavior Signs - continued

Unkempt personal appearance.
Slovenly surroundings.
Persistent financial difficulty.
Frequent hand tremors.
Persistent vague somatic complaints (headaches, fatigue, general malaise).

Disturbances of Mood

When drinking is discussed: evasiveness, open hostility, denial or manipulation (subject is changed, client takes over the interview).
Moodiness and mood swings; outbursts of anger or tearfulness, suicidal gestures.
Depression; lack of motivation.
Complaints of loneliness and helplessness.
Vague fears; free-floating anxiety.

Appendix B

PATHOPHYSIOLOGICAL INTERACTIONS - AGING AND ALCOHOL

Jean Dunlop, R.N., M.A.

Senior Alcohol Services
a program of
Laurelhurst Manor
1025 N. E. 33rd Avenue
Portland, Oregon 97232
(503) 231-0306

PATHOPHYSIOLOGICAL INTERACTIONS - AGING AND ALCOHOL

Jean Dunlop, R.N., M.A.

The physiological effects of alcohol have an additive effect when combined with normal physiological aging of the body. This paper was developed as a handout for workshops and describes some of the processes through which this additive effect occurs. The material was compiled through a review of aging and alloholism literature, and the findings have been confirmed by Senior Alcohol Services' staff during the treatment of elderly alcoholic clients.

I. Neurological Considerations

A. Effects of Aging

Nervous system function is slowed as we grow older. Several mechanisms are responsible. There is a normal loss of about ten percent of one's original brain cells by age 80. (Smith,1977). Nerve cells have no capacity for regeneration so that the loss is irreversible. There is a less effective integrative ability in the nervous system with time. Coordination between neurons, muscles and glands is slowed partially due to a 30 percent reduction in metabolically active cells in the body by age 65 (Weg, 1978; Thompson and Floyd, 1978). There is a ten to fifteen percent loss in nerve conduction in the elderly due to decreased transmission at the synapse. There is considerable evidence that this process is enhanced by a feedback system or "pace-maker" role in the central nervous system which would direct inhibition of brain chemical uptake and release in response to a lesser demand (Weg, 1978). Brain cells are affected by a decrease in oxygen supply. This occurs in part as the result of decreased perfusion of tissue by the heart as we age. There is a 40-50 percent decrease in cardiac output between ages 30-80. Also there is reduced lung efficiency with a measureable decrease in maximum breathing capacity, residual lung volume vital capcity and basal oxygen consumption (Weg, 1978).

B. Effects of Alcohol

Alcohol's most immediately noticeable effect in the body is its effect on the central nervous

system. This acute effect is temporary and brain function returns to normal when the body is free of alcohol. However, with chronic exposure, alcohol causes direct damage to brain cells. Alcoholic brain damage (an organic brain syndrome) can result in a diffuse loss of brain function. It may do this through its interference with protein and nucleic acid synthesis in the brain or via an auto-immune response. With long-term excessive use, pathologically, there is cortical atrophy (shrinking of the brain cortex). Clinically, the result may look like non-alcoholic senile dementia. Whatever the mechanism, alcoholics lose brain cells at an accelerated pace (Smith, 1977). Symptoms are lessened ability to concentrate, impaired abstract reasoning and judgment, disorientation and loss of recent memory (Smith, 1977; Myerson, 1973; Iber, 1971).

Other mechanisms have been described which explain acute as well as chronic effects. Altered ion transfer (sodium and potassium) across brain cell membranes leads to lowering of the action potential of the nerve cell after an initial brief excitory response. Brain chemical (neurotransmitter) levels are affected causing a slowed response at the nerve junctions (synapses). The body's energy-producing system (citric acid cycle) is slowed by the interference of alcohol metabolically at the cellular level. This causes a decreased ability to respond to stimuli. Brain cells may become hypoxic due to the effect of high concentrations of alcohol on red blood cells (RBC's). There is evidence that blood flow is slowed via the "sludging" or agglutinating of RBC's in the presence of alcohol (Smith, 1977). The results of one study showed that as blood alcohol rises there is increased "sludging" of RBC's with slowing of forward flow in small blood vessels. This apparently occurs even in social drinking but seriously damaging effects do not occur at blood alcohol levels below 210mg./100ml (Smith, 1977).

Other brain damage due to alcohol is secondary to its effect on certain nutrients, e.g., folic acid, pyridoxine and thiamin (B vitamins). Alcohol may affect the formation of RBC's in the bone marrow through its effect on folic acid and pyridoxine, causing macrocytic and sideroblastic anemia. The end result is the production of immature and/or iron-deficient RBC's incapable of carrying a normal oxygen supply (Hillman, 1977; Myerson, 1973; Bottiger, 1973). Thiamin deficiency diseases

are commonly seen in late stage alcoholism and may include beri-beri, Korsakoffs psychosis and Wernickes Syndrome. Symptoms include peripheral neuritis and the variety of effects seen in the Wernicke-Korsakoff Syndrome, i.e., opthalmoplegia, nystagmus (eye abnormalities), ptosis (drooping eyelid), ataxia (incoordination), confusion, and loss of memory which is compensated for by confabulation-the making up of events or facts to cover the inability to remember (Smith, 1977).

Hypoglycemia resulting from chronic excessive use of alcohol may cause acute organic brain syndrome which in severe cases may become life-threatening (Forni, 1978). Brain cells are completely dependent on oxygen and glucose. If they are deprived of one or the other for more than a few seconds, they begin to die rapidly. After a few minutes brain death occurs. Some early symptoms are irritability, confusion and disorientation (Smith, 1977).

II. Sleep

A. Effects of Aging

There are normal changes in sleep patterns as one grows older. There is generally less deep or stage four sleep as well as less dream or rapid eye-movement (REM) sleep. Many elderly persons take brief naps during the daytime. These changes are not pathological nor necessarily damaging. However, many elderly persons complain of not sleeping well and can benefit from reassurance that a changed sleep pattern need not be harmful.

Two situations which frequently cause sleep disturbance do need intervention, however. Severe depressive reactions and transient situational disturbances may cause insomnia and should be addressed by treating the underlying problem. Chronic use of sleeping medications should be avoided due to their impairment of already slowed brain function. Additionally, there is the addictive potential with barbiturates and anti-anxiety agents (Pfeiffer, 1978).

B. Effects of Alcohol

Alcohol commonly causes sleep disturbances; e.g., frequent awakening, restlessness, insomnia and night terrors. One of the mechanisms is the suppression of rapid eye movement (REM) sleep

caused by alcohol. Deprivation of REM sleep and deep stage four sleep can lead to symptoms ranging from anxiety and agitation to psychosis. During withdrawal from alcohol REM rebound occurs and stage four sleep is blocked while there is a marked increase in REM sleep. There is considerable indication that these effects of alcohol on sleep stages are due to altered levels of brain chemicals, paticularly serotonin and norepinephrine. It has been found that sleep paterns of middle-aged alcoholics resemble those of elderly non-alcoholics (Smith, 1977).

III. Heart and Circulation

A. Effects of Aging

Cardiac output is decreased by 40 to 50 percent between the ages of 30 and 80 (one percent per year after age 30) (Weg, 1978; Thompson and Floyd, 1978). The normal output is about five liters per minute at age 30. Cardiac reserve is lessened and the heart works harder for a lesser result as the body ages. Circulation time increases and blood pressure tends to rise. The latter is the result of some loss of elasticity of artery walls and can be contributed to as well by atherosclerosis, a condition chracterized by fatty deposits lining blood vessel walls, thereby narrowing the space available for blood circulation. Fifty percent of elderly non-hospitalized people have some cardiac pathology (disease). The two most common cardiac problems in this group are inadequate blood circulation to the heart muscle itself (myocardial ischemia) and arteriosclerosis (hardening of the arteries). This decrease in heart performance has implications for adequate nourishment of other body tissues, as well as for drug dosages (Weg, 1978; Thompson and Floyd, 1978).

B. Effects of Alcohol

Chronic excessive use of alcohol contributes to the normal aging effects on cardiac function. Alcohol causes an initial rise in heart rate in normal persons. It also causes dilation of peripheral blood vessels (blood vessels of the skin). This direct toxic effect is the result of the sympathetic nervous system or stress response, which alcohol elicits, and its subsequent release of adrenalin-type biochemicals. In alcoholics with fatty liver damage alcohol has been found to cause a decrease in cardiac function, and in

non-alcoholic patients with heart disease, even two ounces of whiskey leads to a decrease in stroke output and a decrease in coronary (heart muscle) artery circulation (Smith, 1977).

After alcohol ingestion normal heart muscle cells leak minerals and enzymes, i.e., potassium, phosphate, creatinine phosphokinase (CPK), glutamic-oxalacetic transaminase (GOT), glutamic-pyruvic transaminase (GPT), and lactic dehydrogenase (LDH). Alcoholics leak enzymes when blood alcohol levels reach 200mg./100ml. Triglycerides (breakdown products of fat) invade heart tissue when alcohol is present in the body. It is believed that most chronic alcoholics have some cardiac damage caused by alcohol and demonstrated by a depressed myocardial (heart muscle) function. Congestive failure and arrythmias are the most common clinical findings. Symptoms are dyspnea (shortness of breath), tachycardia (rapid pulse), edema (swelling due to fluid retention), palpitations and a dry cough (Smith, 1977; Myerson, 1973; Regan, 1973).

Alcohol causes other effects on circulation. It raises the fat content of the blood (hyperlipidemia) by mobilizing fat from peripheral storage depots as well as through its effects on fat metabolism in the liver. This may contribute to the development of atherosclerotic cardiovascular disease. In addition there is fatty infiltration of the heart muscle itself and a resulting enlarged flabby heart (Smith, 1977; Myerson, 1973).

The thiamin depletion caused by alcohol may lead to beri-beri heart disease, a condition described as "high output heart failure" (Smith, 1977). Rather than improve cardiac function, recent evidence indicates that alcohol over-all has a damaging effect on the heart and circulatory system.

IV . Liver

A. Effects of Aging

The weight of the liver begins falling after age 50, correlating with total body weight which also falls. The cells become larger and fewer with time. There is some evidence that protein synthesis slows and that there is less ribonucleic acid (RNA) available. RNA is needed for cell

(protein) replacement, e.g., liver enzymes. There is slowed metabolism of drugs iv2$he liver and a decrease in plasma albumin production, both of which have implications for drug dosages and the use of alcohol which is metabolized by the liver (Weg, 1978; Thompson and Floyd, 1978).

B. Effects of Alcohol

Research has shown that fatty encroachment of liver tissue develops in both alcoholic and non-alcoholic persons with or without adequate diet. Severe liver damage may occur with prolonged use of alcohol. This comes about because the alcohol is used as fuel for energy in the liver rather than fat. Fat accumulates as a result and more fat is synthesized due to the availability of hydrogen ions which are provided by the metabolism (breakdown) of alcohol. Fatty liver can lead to alcoholic hepatitis, with swelling, inflamation and tenderness. This condition may reverse with abstinence from alcohol. However, with continued alcohol intake and nutritional deficits, the damaged liver cells may be replaced with connective tissue and cirrhosis, an irreversible condition, may begin (Worthington, 1978; Lieber, 1976,1978; Fenster, 1977).

The liver, when thus damaged, is unable to carry out its many functions effectively. These functions include serving as a blood reservoir (1500 ml or 1/3 the cardiac output per minute), performing detoxification and metabolic activities, acting as a storehouse for vitamins and as a filtration plant for toxins and other debris. Hypoglycemia may result due to the lessened ability to make glucose (gluconeogenesis) from other nutrients, e.g., fats and proteins. Protein synthesis and nucleic acid synthesis also are slowed (Worthington, 1977). The swollen liver may also cause a rise in pressure in the blood supply of the liver (portal hypertension). This may cause the development of varicose veins (swollen veins) in the esophagus (esophaageal varices) which sometimes burst causing massive terminal bleeding. Ascites (collection of fluid in the abdomen) occurs due to portal hypertension as well as to the loss of plasma proteins. These proteins normally exert an osmotic force to keep fluid in its proper compartments (Worthington, 1977; Fenster, 1977).

Another result of alcohol's effect upon the liver is the proliferation, or increase, of additional metabolic pathways in the chronic alcoholic to break down the alcohol. These pathways are used by many other drugs as well as alcohol and their development explains the cross-tolerance and cross addiction which develops between alcohol and some other central nervous system depressants, e.g., barbiturates and anti-anxiety agents. There are other alcohol/drug interactions resulting from this phenomenon as well (Fenster, 1977; Myerson, 1973).

V. Gastro-Intestinal Tract

A. Effects of Aging

Absorption of nutrients and drugs from the small intestine becomes slower and less complete with age. The intestinal villi (small projections of the intestinal surface) become shorter and broader, with decreased absorption capacity. Also, there is a high incidence of achlorhydria (decreased production of stomach acid) with increasing age. This interferes with digestion and with drug absorption from the stomach. There is reduced peristalsis (involuntary motion of the intestinal tract which moves food along), and resulting tendancy toward constipation (Weg, 1978; Thompson and Floyd, 1978).

B. Effects of Alcohol

Alcohol increases gastric secretion and can cause excessive stomach acidity, a fact to which many drinkers can attest. The excess acid causes damage to the protective mucosal lining of the stomach wall. Alcoholic gastritis is one of the most common disorders among heavy drinkers and may contribute to the development of heartburn, ulcers, and gastric and intestinal bleeding. In chronic excessive use alcohol decreases gastric (stomach) motility, thus slowing down the digestive process (Myerson, 1973; Fenster, 1977; Kissin and Begleiter, 1974).

The excess acid production contributes as well to the increased susceptability of alcoholics to esophagitis (inflamation of the esophagus) and the higher incidence of carcinoma of the esophagus seen in alcoholic drinkers (Fenster, 1977.)

Pancreatitis is seen in about 1/3 of all alcoholics with medical complications of alcohol (Israel, 1971). The organ becomes inflamed, causing extreme pain, nausea and vomiting. The condition may be acute or chronic and may be due to an increased production of pancreatic enzymes combined with duct obstruction, or to the direct toxic effect of alcohol on the pancreas (Fenster, 1977; Myerson, 1973; Israel, 1971; Baum and Iber, 1973).

VI. Kidney

A. Effects of Aging

There is a gradual loss in the number of functioning kidney cells during the aging process. Renal (kidney) blood flow, glomerular filtration and tubular excretion rates slow. Between ages 30 and 80 there is a 55 percent decrease of blood plasma flow through the kidneys (Weg, 1978). There is a 46 percent decline in glomerular filtration rate between the ages of 20 and 90. Thus, the kidney's ability to excrete and re-absorp substances slows down as the body ages. One effect of this reduced functional capacity is the slower clearing of drugs and alcohol from the body of the older person. Drug dosages are thus effected by physiological aging (Thompson and Floyd, 1978).

B. Effects of Alcohol

As blood alcohol level rises there is a diuretic effect (increased urination). This is an acute effect and is probably due to alcohol's depressant effect on the production of anti-diuretic hormone (ADH) in the pituitary gland. When excessive urination occurs, significant amounts of potassium and magnesium are lost. These minerals influence muscle contractility and nerve excitability and their loss likely contributes indirectly to alcohol's effect on muscle-nerve coordination both during intoxication and withdrawal. However, as blood alcohol level falls, fluid retention frequently occurs (Smith-DiJulio, Heinemann and Ogden, 1977; Myerson, 1973). This may result from inappropriate secretion of ADH or from the effect of alcohol on the adrenal gland hormone aldosterone which regulates sodium (salt) balance (Myerson, 1973).

In any case, edema (swelling due to fluid retention) is often seen during withdrawal from alcohol and this over-hydration may place an overload on the heart.

VII. Nutrition

A. Effects of Aging

In spite of living in a land where food is plentiful, this nation's elderly are often malnourished. There are several reasons. Loss of appetite occurs secondary to depression which many older persons experience. Many of the elderly live alone and simply do not bother to prepare nutritionally adequate meals for themselves. The "tea and toast" diet is simpler. Contributing to loss of appetite are the sensory deficits which occur progressively with time - particularly the senses of taste, smell and sight (Weg, 1978). Lack of teeth and ill-fitting dentures are common in the older population and all this contributes to the process of malnutrition.

Added to a frequently inadequate food intake, both in quality and quantity, is the reduced digestive and absorptive capacity caused by decreased production of digestive enzymes and acids in the elderly. Motility of the gastro-intestinal tract is slowed as we have already seen (cited above).

Surveys have shown that large numbers of older persons are particularly deficient in serum and tissue levels of calcium, iron, vitamin A, thiamin, riboflavin, niacin, and vitamin C. Many of these deficiencies are sub-clinical but would contribute to the body's lesser ability to accommodate physical stresses (Weg, 1978).

B. Effects of Alcohol

Alcoholics are a second population in which malnutrition is common in spite of adequate food supplies. The major reason is inadequate diet due to anorexia (loss of appetite). Alcohol suppresses the hunger and appetite control centers in the central nervous system (brain). Additionally, it interferes with the absorption, metabolism and distribution of the nutrients which are ingested (Worthington, 1977; Iber, 1971).

Alcohol may be considered a nutrient because it supplies calories for energy (seven calories per

gram). However, these are "empty" calories as alcohol does not carry any other nutrients with it; e.g., vitamins or minerals. If appetite is suppressed and immediate energy needs are being met, other nutrients are not eaten. Not only is alcohol an "empty" calorie, it could also be called a nutrition antagonist due to its many damaging effects upon the nutrients. Some of these are described below.

Digestion and absorption have been found to be impaired in chronic alcoholics, primarily due to alcohol's irritant effect on the lining of the gastro-intestinal tract and the decrease in secretion of digestive enzymes in the pancreas. Alcohol's own metabolism in the liver contributes to nutritional damage by creating a shortage of the enzyme NAD (nicotinamide adenine dinucleatide). This has been termed a "crucial biochemical lesion" by Lieber (Lieber and Davidson, 1962) because of its damaging effects upon many vital metabolic processes in the liver. Thus, alcohol causes a decreased ability of the liver to detoxify (metabolize or break down) other nutrients; e.g., vitamins, proteins, carbohydrates, and fats as well as drugs (Iber, 1971; Worthington, 1977; Myerson, 1973). Because of the altered fat and carbohydrate metabolism, serum lactate levels rise. Lactate interferes with uric acid excretion and the resulting high levels of uric acid frequently cause gouty arthritis.

Other results of this liver malfunction have been cited above: They include the accumulation of fat in the liver (fatty liver) and fatty material in the blood (hyperlipidemia) and (triglyceridemia). Some of the fat may be lodged in the heart muscle and contribute to heart disease. Fatty liver may progress to alcoholic hepatitis, a usually reversible condition with abstinence and nutritional diet. One in ten alcoholics develop cirrhosis, an irreversible condition (Myerson, 1973; Fenster, 1977).

Another result is an initial hyperglycemia (rise in blood sugar level) when drinking begins. Glucose levels remain high when they lose the competition with alcohol for NAD in the liver. However, in chronic alcoholism, when nutritional stores are depleted and the energy producing system in liver cells is depressed, the liver is unaf#D to form glucose from other nutrients (gluconeogenesis) and hypoglycemia (low blood

sugar) may develop after a relatively short period of fasting (Iber, 1971; Myerson, 1973).

Alcohol has a significant effect on protein metabolism. It impairs digestion of protein, inhibits aborption of amino acids, and decreases the synthesis of new protein (body cells, tissues, enzymes, etc.) (Worthington, 1977; Iber, 1971).

Alcohol has similar effects on several vitamins, inhibiting absorption and interfering with metabolism (break down) of pyridoxine, folic acid and other B vitamins as well as the fat-soluble vitamins (A, D, K). Chronic alcoholics have long been known to have a higher than average incidence of vitamin deficiency diseases; i.e., beri beri, pellegra, and pernicious, macrocytic and iron-deficient anemias. Thiamin deficiency is the most common among late-stage alcoholics and is manifested in the Wernicke-Korsakoff syndrome described earlier and other muscle-nerve effects, e.g., peripheral neuropathy (Worthington, 1977; Iber, 1971).

Alcohol causes urinary excretion of potassium, magnesium, calcium, phosphorous, and zinc (Worthington, 1977; Iber, 1971). Calcium and phosphorous are needed for proper bone mineralization. Potassium, magnesium and calcium also exert an influence on muscle contractibility and nerve irritability. Many alcoholics have other symptoms of vitamin deficiency such as dry flaky skin, reddened sore mouth and tongue and slow healing of cuts, wounds and infections.

VIII. Stress Response

A. Effects of Aging

There is a lessened ability to adjust to change physiologically with age. Homeostasis or balance is therefore at risk. The values of blood sugar, blood proteins, PH (measure of acidity), blood volume, heart rate and blood pressure are usually stable in the young and the old. Under physical or emotional stress, exercise or disease, variations from normal are wider and recovery is slower in the elderly. This displacement can be measured by urinary levels of adrenalin and related hormones (noradrenalin, and adrenocorticotrophic hormone - ACTH (Weg, 1978).

B. Effect of Alcohol

The body seems to respond to alcohol as it does to an emergency or stress situation. Plasma cortisol levels are raised during an acute drinking episode, the level rising with the degree of intoxification (Myerson, 1973). The sympathetic nervous system is thus triggered into action and this prompts a rise in blood sugar, pulse rate and blood pressure. These values fall with the increasing depressant effect of alcohol on body systems. In the case of the older chronic alcoholic, one would expect the body to become less and less able to make the physiological response to stress due to the already slowed stress response resulting from normal aging.

The foregoing review points to some suggestions. There are obvious implications for drug (and alcohol) dosages due to the decreases in absorption, metabolism, distribution and excretion of these substances in elderly persons. Serious consideration needs also to be given to the questionable benefit of the use of alcohol as a "mood elevator" and social lubricant for the depressed and isolated elderly when balanced against the insidious potential of physical, emotional and social deterioration which can result.

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ADDING DRUGS TO THE ELDERLY ALCOHOLIC'S PHYSIOLOGY

Jean Dunlop, M.A.,
R.N.,C.A.C.

There are obvious implications for drug and alcohol dosages in the decrease in absorption, metabolism, distribution, and excretion of drugs seen in elderly persons. There are some specific interactions.

1. There is potentiation of all central nervous system depressants: barbiturates, sedatives, narcotics, and tranquilizers. There is a prolonged half-life (prolonged effect) of these drugs in the elderly. Thirty to 40 percent of all prescriptions to the elderly are in these categories.

2. There is a frequency of paradoxical or abnormal response to central nervous system depressants in the elderly (Weg, 1978).

3. Following is a list of nutrition considerations for drug-induced malnutrition:

   a. Vitamin B absorption is decreased by oral antidiabetic medications, hydralazine (an antihypertensive medication) and l-dopa (antiparkinsonism medication). Vitamin B is needed by the nervous system for adequate function. Deficiency causes neurological symptoms. Alcohol inhibits absorption of B vitamins, as does the aging process (Weg, 1978: Iber, 1971).

   b. Vitamin C absorption is blocked by alcohol and aspirin (Weg, 1978). A deficiency of Vitamin C may cause subcutaneous bleeding, slow healing, and bleeding gums.

   c. Magnesiun and potassium are excessively excreted during diuretic therapy and when alcohol is in the body. A loss of potassium may alter the nerve impulse to the heart. Magnesium influences nerve excitability and muscle contractility. A loss of magnesium and potassium in combination with hypotensive medication (blook pressure medications) may lead to temporary confusion, lethargy or low energy level (Weg, 1978: Worthington, 1977).

   d. Adsorption of floride and phosphorous are inhibited by antacids containing aluminum (Weg, 1978). Many heavy drinkers as well as older people take antacids. A deficinecy of phosphorous can cause an alteration in calcium absorption and excretion. Calcium loss may lead to osteoporosis and osteomalacia - bone diseases frequently seen in the elderly. Fractured hips are a common result.

4. Psychotropic Medications

   a. Antipsychotic (e.g., thorazine) and antianxiety agents (e.g., librium or valium) may lower blood pressure to the point of inadequate oxygen supply to the brain. Symptoms are mental condusion, drowsiness, and restlessness. Alcohol adds to the effect of these drugs.

b. Antidepressant medications may contribute to worsening a psychosis or to high blood pressure by raising blood levels of adrenalin-type biochemicals. With alcohol, they may cause a drop in blood pressure and contribute to slowing the action of the central nervous system. Alcohol and another class of antidepressant medications (MAO inhibitors) may lead to hypertension or high blood pressure. Many depressions of the elderly are reactive and need social intervention rather than chemical intervention.

5. Insulin and oral antidiabetic medications with alcohol lead to an increased hypoglycemia or low bloodsugar. Symptoms include mental confusion, poor judgement, and irritability.

6. Special Metabolic Changes

   a. When a heavy drinker takes anticonvulsants (dilantin), anticoagulants (coumadin), or oral antidiabetics such as tolbutamide or diabinese, there is an increased effect of the medication when alcohol is in the body and a decreased effect when the person is alcohol-free (Myerson, 1973).

7. The combined effects of the aging body, alcohol, and many commonly prescribed drugs can lead to symptoms of senility as well as a variety of medical complications.

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SENIOR ALCOHOL SERVICES
A PROGRAM OF
LAURELHURST MANOR
1025 N. E. 33rd Avenue
Portland, OR 97232
231-0306

Appendix C

CLINICAL TREATMENT ISSUES

The following are treatment issues with which the alcoholism counselor should be familiar. Not all issues apply to all elderly patients, but are characteristics representative of the older population in general.

1. Treatability: The elderly respond to treatment as well as any age group.

2. Slowed Motor Skills: The elderly may not perform as quickly as their younger counterparts.

3. Reversible vs. Irreversible Brain Damage: Often, those who appear to have suffered irreversible brain damage have not. Recovery for some is a long-term process spanning many months. DO NOT ASSUME IRREVERSIBLE BRAIN DAMAGE.

4. Profanity: Many, if not most, do not appreciate profanity. This is a number one complaint of the elderly in treatment programs.

5. Self-disclosure: The older generation were taught not to talk about their problems. They respond better to gentle inquiry than to heavy confrontation.

6. Reminiscence: Keeping people in the "here and now" during therapy is the norm, and with good reason. For the elderly, however, reminiscence is a necessary function of the life review process which is a task of this developmental stage.

7. Loss: Everyone has suffered loss. Younger populations can probably recapture their losses. The elderly have suffered irretrievable loss.

8. Grieving: The grieving process may be interrupted by the use of alcohol. Completing the process may be important, particularly with respect to irretrievable loss.

9. Personality Traits: Personality and character traits are firmly established in the elderly. The goal of treatment may simply be to stop drinking. Other changes may not occur or even be necessary.

10. Role Reversal: Frequently seen in families of the elderly is the reversal of the parent role. Adult children believing they are helping sometimes "parent" mom or dad. This "taking charge of" the older person contributes to a loss of self-esteem via the subtle message that he/she is no longer capable. This dynamic can often be addressed in family counseling sessions.

11. Seduction vs. Confrontation: Many elderly have a low self-image due to a variety of causes. The present Western culture does not value old age. The loss of physical youth, career (after retirement), frequently a mate, health, etc. contribute to this process. The older person responds to approaches which

build self-esteem rather than the negative confrontation used in many traditional treatment programs.

12. Need for Touch: For many older people, it has been years since physical touch has been experienced. This is particularly true of the withdrawn, isolated elderly who live alone. Touching has an especially high therapeutic value with many people in this age group.

13. Peer (age) Group: The clients at SAS have expressed many times their appreciation of a group of people of "my own age." Many commonalities in life experiences are shared and members feel understood by others who have "been there too."

14. One-to-One: Because many elderly have such strong convictions about keeping personal problems to themselves, they often need more individual counseling than younger clients who more readily may discuss concerns in a group setting. If left to be individually responsible for "using the group," the older person may never address important issues, so strong is his aversion to self-disclosure.

15. Aftercare-Support System: The elderly at SAS have been found to respond deeply to the aftercare group. Many members appear to use this twice-a-week contact with other recovering persons as not only a primary support for sobriety, but also as a "family." Bonds grow strong, friendships deepen, and members show care and concern for each other in a way which seems unique in its power. This process has seemed to demonstrate the added need the elderly recovering person has for a strong social support system which is, as well, a support for sobriety.

APPENDIX D

FAMILY ISSUES IN ELDERLY ALCOHOLISM

I. ENABLING: The family, friends, and members of helping professions often inadvertently enable the elderly alcoholic to continue drinking longer and more comfortably by rescuing him/her from the painful results of the drinking. This process is called "enabling" and may occur in the following ways.

A. Denial

The stigma attached to alcoholism often leads the family of the alcoholic to deny the existence of an alcohol problem as much as or more than the alcoholic himself does.

The elusive nature of the illness contributes to prolonging denial. There often are periodic remissions during the relentless downward progression of the disease. These periods, when the alcoholic seems to have control over the drinking, easily contribute to the denial of the family that there is a problem.

B. Attitudes and Myths

Hopelessness and helplessness on the part of concerned others often prevent the referral of the elderly alcoholic for help. "What's the use? He/she will never stop drinking." "You can't teach an old dog new tricks" is a false belief which contributes to the feeling of hopeless helplessness.

"Drinking is one of the last few pleasures Mom/Dad still has." These words describe the myth that alcohol brings happiness - a belief commonly held by families who are unaware that the loneliness and depression they think alcohol is relieving are actually the miserable results of the excessive drinking.

C. Mistaken Diagnosis

Alcoholism may masquerade as senility, depression, and/or other drug side effects and may, therefore, go unrecognized. Many symptoms of these conditions are identical. The need for a differential diagnosis by concerned others, i.e., family, friends and members of the helping profession, is critical. When any or all of these conditions exist simultaniously with alcoholism, it is necessary to remove the alcohol before an accurate assessment may be made of the others.

II. PARENTING: Elderly alcoholics are particularly vulnerable to the role reversal which often occurs between the elderly and younger members of the family. Adult children assume the parent role as excessive drinking renders the alcoholic less and less able to manage his life. Health problems increase and as the situation deteriorates, concerned others begin protecting and assuming responsibility for the alcoholic. As the control over his life is taken over more and more by the children who make decisions and offer unrequested advice, the self-esteem of the alcoholic plummets deeper. The well-meaning family becomes frustrated and exhausted and family relationships deteriorate. At this point there is need for education of the family about alcoholism as well as family therapy.

It is often difficult to assess the difference between offering a legitimate helping hand due to some of the natural impairments which result from the aging process and falling victim to the manipulations of a practicing alcoholic.

"Parenting" may be percieved by the elderly as a colossal "put-down." They respond best to attitudes of respect and approaches which build self-confidence and self-esteem.

III. A FAMILY ILLNESS: Alcoholism in the elderly affects family members in some unique ways. Most severly affected, next to the spouse if there is one, are the adult sons and daughters who often feel guilt about the uncontrolled drinking of their loved one. Though this process occurs in families of younger alcoholics, the effect seems more profound in the case of the elderly where the reuslts of the drinking are usually more critical and life-threatening. Adult sons and daughters and spouses feel guilty and responsible, yet exasperated and helpless. Feelings become jumbled and commonly include, besides guilt, resentments, anger, frustration, helplessness and hopelessness. Emotional illness is not an uncommon result. The family often goes to elaborate lengths in attempting to stop or control the drinking. Family relationships are undermined in the process and bitter alienation may eventually occur.

Education about alcoholism and counseling are important to include in the treatment of the family. Communication patterns are usually damaged and can be improved in family counseling sessions.

It is essential to consider all of the above family issues when planning treatment for the elderly alcoholic.

Senior Alcohol Services
P.O. Box 425
Vancouver, WA 98666
Phone: (206) 694-6577